HCBW APPLICATION FORMAT

VERSION: 4/01/94 - modified 4/95

FOR USE IN SUBMITTING WAIVER

REQUESTS UNDER

SECTION 1915(c)

OF THE

SOCIAL SECURITY ACT

SECTION 1915(c) WAIVER FORMAT

1. The State of Connecticut requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A

   This is a request for a model waiver.

   a. ☐Yes b. ☒ No

   If yes, the State assures that no more than 200 individuals will be served on this waiver at any one time.

   This waiver is requested for a period of (check one):

   a. ☒ 3 years (Initial waiver)

   b. ☐5 years (Renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a. ☐ Nursing facility (NF)

   b. ☒ ICF for the mentally retarded or persons with related conditions (ICF/MR)

   c. ☐ Hospital

   d. ☐ NF (served in hospital)

   e. ☐ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) if individuals who would be otherwise eligible for waiver services:

   a. ☐ aged (age 65 and older)

   b. ☐ disabled

   c. ☐ aged and disabled

   d. ☒ **mentally retarded as defined in Connecticut General Statute 1-1g, or otherwise eligible for services from CT DMR under state law, Con Gen Stat Sec 17a-210. Also included are those determined eligible for DMR services as a result of a hearing conducted by DMR according to the**

Uniform Administrative Procedures Act or administrative determination of the Commissioner.

e. ☒ developmentally disabled f. ☐ mentally retarded and developmentally disabled

g. ☐ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested in order to impose the following additional targeting restrictions (specify):

a. ☒ Waiver services are limited to the following age groups (specify): Persons age three and above.

b. ☐ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c. ☒ Waiver services for persons who are developmentally disabled are limited to persons who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of care of an ICF/MR. Also included are young children between age three and age of seven who have a significant level of developmental delay, which cannot yet be accurately diagnosed, or have a specifically diagnosed condition with a high probability of resulting in mental retardation.

d. ☒ Other criteria (specify):

The person lives in his/her own or family home and not in a residence licensed or certified by the Department of Mental Retardation.

The individuals who will be supported by this waiver will be reflective of the current population served by DMR, but may have many more natural or informal supports available to them, and will be able to take advantage of the flexibility and variety of service options in this waiver to remain in their own or family home. Individuals in this waiver will not require paid 24 hour care or supervision, as a waiver service, as a result of the natural or informal supports in place, or as a result of the individual's level of supervision needs. These factors, and the flexibility and variety of services offered, will allow individuals to be effectively supported by a waiver with a more limited benefit package.

e. ☐ Not applicable.

5. A waiver of the "statewideness" requirements set forth in section 1902 (a)(1) of the Act is requested.

   a. ☐ Yes B. ☒ No

6. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to waiver recipients.

7. The State requests that the following home and community-based services, as described
   and defined in appendix B.1 of this request, be included under this waiver:

   a. ☐ Case management

   b. ☐ Homemaker

   c. ☐ Home health aide services

   d. ☒ Personal care services

   e. ☒ Respite care

   f. ☐ Adult day health

   g. ☒ Habilitation

      ☒ Residential habilitation

      ☐ Day habilitation

      ☐ Prevocational services

      ☒ Supported employment services

      ☐ Educational services

      ☒ IS Habilitation

      ☒ Group Day Services

      ☒ Individualized Day Support

   h. ☒ Environmental accessibility adaptations

      ☒ Vehicle Modification Service

i. ☐ Skilled nursing

j. ☒ Transportation

k. ☒ Specialized medical equipment and supplies

l. ☐ Chore services

m. ☒ Personal Emergency Response Systems

n. ☐ Companion Services

o. ☐ Private Duty Nursing

p. ☒ Family Training

q. ☐ Attendant Care

r. ☐ Adult Residential Care

☐ Adult Foster Care

☐ Assisted Living

s. ☐ Extended State plan services:
Check all that apply:

☐ Physician services

☐ Home health care services

☐ Physical therapy services

☐ Occupational therapy services

☐ Speech, hearing and language services

☐ Prescribed drugs

Other (specify)

t. ☒ Other services (specify):

☒ **Consultative Therapy Services**

☒ **Family and Individual Consultation and Support (FICS)**

☒ Fiscal /Employer Agent Services/Functions

8. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

9. Eligibility groups included under the waiver are reflected in Appendix C-1.

   Waiver recipients meet the appropriate State plan requirements for the eligibility groups included under the waiver unless § 1902(a)(10)(C)(i)(III) has been waived in order to use income and resource rules for the medically needy.

   Under a medically needy waiver of § 1902(a)(10)(C)(i)(III), you may apply eligibility policies that differ from those normally used to determine eligibility for individuals who are living in the community. The income standards and methods employed for the medically needy under this waiver do not result in individuals' income exceeding the Federal financial participation (FFP) limits of § 1903(f).

   a. A waiver of § 1902(a)(10)(C)(i)(III) is requested.

      1☐ yes 2. ☒ not applicable

   b. Computation of income for purposes of FFP limits is based on one of the following. **Check all that apply.**

      ☒ Only the individual's income is compared to a one person medically needy income standard when you choose to use institutional eligibility rules to determine whose income is used in determining eligibility.

      ☐ The individual and spouses' income is compared to the appropriate medically needy income standard for a family of the same size when spouses' and/or parents' income is used to determine eligibility. That is, community rules are used to determine whose income is used to determine eligibility.

      ☐ The individual and parents' income is compared to the appropriate medically needy income standard for a family of the same size when spouses' and/or parents' income is used to determine eligibility. That is, community rules are used to determine whose income is used to determine eligibility.

   c. The income and resource exceptions applied under the waiver are described in Appendix C-2.

10. Appendix C-3 reflects the post-eligibility income deductions for individuals whose eligibility is determined under

§ 435.217.

11. An individual written plan of care will be developed by qualified individuals for each recipient under this waiver utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and their family. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services that are not included in the individual written plan of care.

12. Waiver services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

13. Federal financial participation will not be available in expenditures for the cost of room and board, except when provided as part of respite care in a facility approved by the State that is not a private residence. Meals provided under any waiver service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

14. The State will refuse to offer home and community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of a level of care referred to in item 2 of this request.

    a. ☒ Yes b. ☐ No

15. The Medicaid agency provides the following assurances to CMS:

    a. Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those standards include:

        1. adequate standards for all types of providers that provide services under the waiver (see Appendix B);

        2. assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

        3. assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet

the requirements of 45 CFR Part 1397 for board and care facilities. These facilities will be used for the limited purpose of respite.

b. The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services.

c. When a recipient is determined to be likely to require a level of care indicated in item 2 of this request, the recipient or his or her legal representative will be:

1. informed of any feasible alternatives under the waiver; and

2. given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in the setting(s) indicated in item 2 of this request, in the absence of the waiver.

g. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the recipients. The information will be consistent with a data collection plan designed by CMS.

h. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. ☒ Yes b. ☐ No

16. At the State's option, the State will provide for an independent assessment of its waiver (except as CMS may otherwise specify for particular waivers) that evaluates the quality of care provided, access to care, and cost-effectiveness. The results of the optional assessment will cover all but the last fiscal year of the waiver, and can be submitted to CMS 90 days prior to the expiration of the approved waiver.

a. ☐ Yes b. ☒ No

17. The State assures that it will have in place a formal system by which it ensures the health and welfare of the recipients, through monitoring of the quality control procedures described in this waiver document. Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures the State will ensure the quality of services furnished under the waiver and the State plan to waiver recipients. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiency.

18. An effective date of TBD is requested.

19. The State contact person for this request is Michele Parsons who can be reached by telephone at 860-424-5177.

20. This document, together with Appendices A through G, and all attachments, constitutes the State of Connecticut's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print name: _____

Title: _____

Date: _____

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

__X__ The waiver will be operated by **The Department of Mental Retardation**, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

____ The waiver will be operated by _____, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. ___ Case Management

___ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1.___Yes 2.___No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1.___Yes 2.___No

___ Other Service Definition (Specify):

_____

_____

b.____ Homemaker:

___ Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

___ Other Service Definition (Specify):

c.____ Home Health Aide services:

___ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

___ Other Service Definition (Specify):

d._X_ Personal care services:

___ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

___ Payment will not be made for personal care services furnished by a member of the individual's family.

__X__ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

__X__ Family members who provide personal care services must meet

the same standards as providers who are unrelated to the individual.

___ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

___ A registered nurse, licensed to practice nursing in the State.

___ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

__ Case managers

_X_ Other (Specify):**The waiver recipient or the recipient's representative will supervise the personal care provider on a day to day basis when hiring their own providers. Recipient's hire, train and supervise qualified providers of the recipient's choice. Recipient's are free to terminate the provider's employment and select new providers. Recipients also have the choice of receiving personal care services through a qualified agency.**

3. Frequency or intensity of supervision (Check one):

_X_ As indicated in the plan of care

___ Other (Specify):

4. Relationship to State plan services (Check one):

__X__ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

__X__ **Other service definition (Specify): Personal Support - assistance necessary to meet the individual's day-to-day activity and daily living needs and to reasonably assure adequate support at home and in the community to carry out personal outcomes. Cueing and supervision of activities is included. This service may not be used in place of eligible Medicaid State Plan Home Health Care services. Provision of services is limited to the person's own or family home and/or in their community**

(a) Services may be provided by a qualified family member or relative, independent contractor or service agency. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a participant's spouse, a conservator or a relative of a conservator. For other family members, federal financial participation is allowable only when: the service provided is not a function which the spouse or parent would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family,

(b) the service would otherwise need to be provided by a qualified provider.

The benefit package in this waiver includes a limitation of up to $8,000 per year based on assessed need for Personal Support. This service may not be used in combination with residential habilitation. A recipient's annual expenditure for Personal Support may exceed $8,000, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences of the individual or family. Through a prior approval process, additional services will be approved based on an assessed need, and if the total expenditures for this service, respite, PERS, and IS habilitation do not exceed $22,000 annually, or, those services in combination with day/employment services and transportation combined do not exceed $40,000 annually.

e. X Respite care:

X Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

___ Other service definition (Specify):

_____

_____

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

X Individual's home or place of residence

X Foster home

___ Medicaid certified Hospital

___ Medicaid certified NF

X Medicaid certified ICF/MR

___ Group home

__X__ Licensed respite care facility

__X__ Other community care residential facility approved by the State that its not a private residence (Specify type): DMR operated Respite Centers; community locations

___ Other service definition (Specify):

The benefit package in this waiver includes a limitation of up to $2,000 per year for Respite. This service may not be provided in combination with residential habilitation. A recipient's annual expenditure for respite may exceed $2,000, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences and needs of the individual or family. Through a prior approval process, additional services will be approved based on an assessed need, and if the total expenditures for this service, personal support, and IS habilitation do not exceed $22,000 annually, or those services in combination with day/employment services and transportation combined do not exceed $40,000 annually.

f.____ Adult day health:

___ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1.___Yes 2. ___ No

___ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. X Habilitation:

X Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

X Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting.–Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. . Payments will not be made for the routine care and supervision that would be expected to be provided by a family or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

Residential habilitation services are limited to adults who live in their own home and are supported by a Supported Living agency. The benefit package in the waiver includes a limitation of up to $22,000 per year based on assessed need, and can not be used in combination with respite, IS habilitation or personal support. A recipient's annual expenditure for residential habilitation may exceed $22,000, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences or needs of the individual. Through a prior approval process, additional services will be approved based on an assessed need, and if the total expenditures for this service, group day,

individual day, supported employment, transportation and PERS combined do not exceed $43,000 annually.

___ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

___ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs

Check one:

___ Individuals will not be compensated for prevocational services.

___ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not <u>primarily</u> directed at teaching specific job skills,

but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

___ Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

__X__ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations,

supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

The State will require prior institutionalization in a NF or ICF/MR before a recipient is eligible for expanded habilitation services (prevocational, educational and supported employment).

1.___Yes 2.__X__No

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation

services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1 Yes 2. X No

The benefit package in this waiver includes a limitation of up to $17,500 per year based on assessed need for supported employment. This benefit limit is considered in combination with any group day services and/or individualized day support the recipient has received in the plan year. A recipient's annual expenditure for supported employment may exceed $17,500, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences and needs of the individual. Through a prior approval process, additional services will be approved based on an assessed need, and if the total expenditures for this service, residential habilitation, IS habilitation, respite, personal support, PERS and/or transportation combined do not exceed $40,000 annually.

X Other service definition (Specify): :

IS Habilitation: assist with the acquisition, improvement and/or retention of skills and provide necessary support to achieve personal outcomes that enhance an individual's ability to live in their community as specified in the plan of care. This service is not available for use in licensed settings. Payments for IS habilitation are not made for room and board. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

Provision of services is limited to the person's own or family home and/or in their community.

Services may be provided by a qualified family member or relative, independent contractor or service agency. In the case of providers who are family members, federal financial participation is excluded when the provider is a parent providing services for a minor child under the age of 18, a

participant's spouse, conservator, or a relative of a conservator. For other family members, federal financial participation is allowable only when: the service provided is not a function which the spouse or parent would normally provide for the individual without charge as a matter of course in the usual relationship among members of a nuclear family; and, the service would otherwise need to be provided by a qualified provider.

IS habilitation may not be used in combination with residential habilitation. The benefit package in this waiver includes a limitation of up to $12,000 per year based on assessed need for IS habilitation. A recipient's annual expenditure for IS habilitation may exceed $12,000 subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences and needs of the individual. Through a prior approval process, additional services will be approved based on an assessed need, and if the total expenditures for this service, respite, personal support, and/or PERS combined do not exceed $22,000 annually, or those services in combination with day/employment services and transportation combined do not exceed $40,000 annually.

Group Day Services - Includes Sheltered Workshops and Group Day Support Options provided outside of the home. Services and supports lead to the acquisition, improvement and/or retention of skills and abilities to prepare an individual for work and/or community participation, or support meaningful socialization, leisure and retirement activities. These services are delivered in or from a facility-based program.

Individualized Day Support : Services and supports provided to individuals tailored to their specific personal outcomes related to the acquisition, improvement and/or retention of skills and abilities to prepare and support an individual for work and/or community participation and/or meaningful retirement activities, or for an individual who has their own business, and could not do so without this direct support. This service is not provided in or from a facility-based program.

The benefit package in this waiver includes a limitation of $17,500 per year based on assessed need for group day and/or individualized day support services. This benefit limit is considered in combination with any supported employment services the recipient has received in the plan year. A recipient's annual expenditure for group day or individualized day support may exceed $17,500, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences and needs of the individual. Through a prior approval process, additional services will be approved based on an assessed need, and if the total expenditures for this service, residential habilitation, IS habilitation, respite, personal support, PERS and/or transportation combined do not exceed $40,000 annually.

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. X Environmental accessibility adaptations:

X Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. **The benefit package is limited to a maximum of $10,000 within the three year period per recipient for environmental modifications and vehicle modifications combined. Once this cap is reached, $300 per individual per year may be allowable for**

repair, replacement or additional modification with prior approval.

_____

__X__ Other service definition (Specify):

Vehicle Modification Services: Alterations made to a vehicle which is the individual's primary means of transportation, when such modifications are necessary to improve the individual's independence and inclusion in the community, and to avoid institutionalization. The vehicle may be owned by the individual, a family member with whom the individual lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

The benefit package is limited to a maximum of $10,000 within the three year period per recipient for environmental modifications and vehicle modifications combined. Once this cap is reached, $300 per individual per year may be allowable for repair, replacement or additional modification with prior approval.

i.____ Skilled nursing:

___ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

_____

_____

j.__**X**__ Transportation:

__**X**__ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in

accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

The benefit package for this service is limited to $2,000 for transportation per plan year. A recipient's annual expenditure for transportation may exceed $2,000, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences and needs of the individual. Through a prior approval process, additional services will be approved based on an assessed need to support the individual plan outcomes, and if the total expenditures for this service, residential habilitation, IS habilitation, respite, personal support, day services, supported employment, and/or PERS combined do not exceed $40,000 annually.

Other service definition (Specify):

k. **X** Specialized Medical Equipment and Supplies:

X Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation**. Prior approval will be required with documentation by a licensed therapy professional for single items costing more than $750. The benefit package is limited to $3,000 over the three year period of the waiver per recipient.**

__ Other service definition (Specify):

l.____ Chore services:

___ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

___ Other service definition (Specify):

_____

_____

m. _X_ Personal Emergency Response Systems (PERS)

_X_ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

___ Other service definition (Specify):

_____

_____

n. ___ Adult companion services:

___ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual.

This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

___ Other service definition (Specify):

o.____ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p.__X__Family training:

__X__ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

q.____ Attendant care services:

___ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

___ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and

intensity of supervision will be specified in the individual's written plan of care.

___ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

___ Other supervisory arrangements (Specify):

_____

_____

___ Other service definition (Specify):

_____

_____

r.____ Adult Residential Care (Check all that apply):

___ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed__). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult foster care services.

___ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way

that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

___ Home health care

___ Physical therapy

___ Occupational therapy

___ Speech therapy

___ Medication administration

___ Intermittent skilled nursing services

___ Transportation specified in the plan of care

___ Periodic nursing evaluations

___ Other (Specify)

_____

_____

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

___ Other service definition (Specify):

_____

_____

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s. **X** Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

Consultative Services – services that assist natural support persons and/or paid support staff in carrying out individual treatment/support plans, which are not covered by the Medicaid State Plan, necessary to improve the individual's independence and inclusion in their community. Consultation activities are provided by professionals in psychology, speech therapy, occupational therapy, physical therapy, nutrition, counseling and behavior management. The service may include the development of a home treatment/ support plan, training to carry out the plan and monitoring of the individual and the provider in the implementation of the plan. This service may only be delivered in the individual's home or in the community as described in the treatment/support plan.

The benefit package for the waiver is limited to $2,000 per plan year. A recipient's annual expenditure for consultative services may exceed $2,000, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences and needs of the individual. Through a prior approval process, additional services will be approved based on an assessed need

to support the individual plan outcomes, and if the total expenditures for this service, FICS, and/or specialized equipment and supplies combined does not exceed $6,000 annually.

Family and Individual Consultation and Support (FICS): Support and Consultation provided to individuals and/or their families to assist them in directing their own plan of individual support. This service is limited to those who direct their own supports and hire their own staff. The services included are :

- **Assistance with managing the Individual Budget**
- **Support with and training on how to hire, manage and train staff**
- **Accessing community activities and services, including helping the individual and family with day to day coordination of needed services.**
- **Developing an emergency back up plan**
- **Self advocacy training**

The benefit package for the waiver is limited to $3,000 per plan year. A recipient's annual expenditure for FICS may exceed $3,000, subject to prior authorization review at either the time of the annual plan or at a time when needs change, consistent with the preferences and needs of the individual. Through a prior approval process, additional services will be approved based on an assessed need to support the individual plan outcomes, and if the total expenditures for this service, consultative services, and/or specialized equipment and supplies combined does not exceed $6,000 annually.

Fiscal/Employer Agent: Service/function that assists the family and/or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of employment of service workers by the family or individual, including Federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, etc. This service will be delivered as an administrative cost. This service is required to be utilized by individuals and families who choose to hire their own staff and self-direct their plan of care. See attachment Appendix B, Attachment 1 and 2, B37-B43 inclusive, for DMR Fiscal Intermediary Procedures.

t.____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

_ Other State plan services (Specify):

_____

_____

u.____ Services for individuals with chronic mental illness, consisting of (Check one):

___ Day treatment or other partial hospitalization services (Check one):

___ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

_____

_____

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

___ Other service definition (Specify):

_____

_____

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

SERVICES	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARDS

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICES	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARDS
Personal Support	Individual Provider, private agencies		Individual Provider – self-directed only with approved Individual Support Agreement. Agency - enrolled as a Qualified Provider of Personal Support Services with DMR	Individual Provider Qualifications – see attachment
Respite	Individual Provider, private agencies and DMR facilities	DMR for Private Agencies and Community Training Homes	Individual Provider – self-directed only with approved Individual Support Agreement DMR for DMR facilities	CT General Statute (CGS) CGS 17a-218 State Administrative Code 17a-218-1 to 17a-218-17
Residential Habilitation (Supported Living)	DMR & Private agencies		DMR	CGS 17a-227 State Administrative Code 17a-227-31 to 17a-227-37 DMR Standard Contract
Supported Employment Services	Individual provider, DMR & Private Agencies		Individual Provider – self-directed only with approved Individual Support Agreement Agency - enrolled as a Qualified Provider of SE Services.	CGS 17a-228 DMR Standard Contract DMR Day Services Definitions Individual Provider Qualifications-see attachment

SERVICES	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARDS
IS Habilitation	Individual Provider, Private agencies		Individual Provider – self-directed only with approved Individual Support Agreement Agency - enrolled as a Qualified Provider of IS Hab Services with DMR	Individual Provider Qualifications– see attachment
Group Day Services	Private agencies and DMR		Agency - enrolled as a Qualified Provider of Group Day Services with DMR	Individual Provider Qualifications-see attached
Individualized Day Support	Individual Provider and Private agencies		Individual Provider – self-directed only with approved Individual Support Agreement Agency - enrolled as a Qualified Provider of Individualized Day Support with DMR	Individual Provider Qualifications– see attachment
Environmental Modifications	Private Providers			NFPA Life Safety Code State Building Code
Vehicle Modifications	Private Contractor or Business			CGS 10-102-18(j) and has Dept. of Motor Vehicles Dealer's Registration

SERVICES	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARDS
Transportation	Individual Provider or Private Transportation Service		Individual Provider – self-directed only with approved Individual Support Agreement	Individual Provider: Valid CT driver's license and insured vehicle. Private Transportation Service: DSS Medicaid Transportation Provider
Adaptive Aids	Private Vendors Pharmacies	Pharmacies: CT Dept. of Consumer Protection Pharmacy Practice Act: Regulations Concerning Practice of Pharmacy Section 20-175-4-6-7		Private Vendors: Conn. State Agency Reg. Section 10-102-3(e)(8) Dept. of Admin. Services Bureau of Purchasing/Purchasing Manual 11/91 Direct Purchase Activity No. 8-F (CGS 4a-50 and 4a-52.
Personal Emergency Response Systems	Private Vendor		Agency - enrolled as a Qualified Provider of PERS Services with DMR	Regulations of CT. State Agencies 17-134-165 Providers Shall: • Provide trained emergency response staff on a 24-hour basis • Have quality control of equipment • Provide service recipient instruction and training • Assure emergency power failure backup and other safety features • Conduct a monthly test of each system to assure proper operation • Recruit and train community-based responders in service provision • Provide an electronic means of activating a response system to emergency medical and psychiatric services, police or social support systems.
Family and Individual Consultation and Support (FICS):	Individual Provider and Private Agencies		Individual Provider – self-directed only with approved Individual Support Agreement Agency - enrolled as a Qualified Provider of FICS Services with	Individual Provider Qualifications – see attached

SERVICES	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARDS
			DMR	
Family Training	DMR Clinicians,		DMR	Dept. of Administrative Services, Bureau of Human Resources Job Specifications (for DMR staff) CGS Title 20 – Licensure
Consultative Services	Private clinicians: Agency or Individual Provider		Individual Provider – self-directed only with approved Individual Support Agreement Agency - enrolled as a Qualified Provider of Consultative Services with DMR	Documentation of applicable licensure/certification from the Department of Public Health or qualifications as indicated in attachment.

ATTACHMENT TO APPENDIX B-2

SERVICE: Personal Support:

Certification	Individual Qualifications
Self-Directed *Ind/Family Agreement with DMR-ISA *Ind/Family or surrogate demonstrates ability to manage own supports *Ind/Fam utilizes an approved FIO **Agency** Enrolled as a Qualified Provider of Personal Support with DMR	Prior to Employment • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the ind/family • have ability to complete record keeping as required by the employer Prior to being alone with the Individual: • demonstrate competence in knowledge of DMR policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques • demonstrate competence in their role necessary to safely support the individual as described in the IP • Medication Administration* * if required by the individual supported

SERVICE Respite:

Certification	Individual Qualifications
Self-Directed *Ind/Family Agreement with DMR-ISA *Ind/Family or surrogate demonstrates ability to manage own supports *Ind/Fam utilizes an approved FIO **Agency** Enrolled as a Qualified Provider of Respite	Prior to Employment: • 18 yrs of age (self-directed 16 years of age) • criminal background check • registry check Self-directed or Agency Provided Individual Provider: : Prior to being alone with the Individual: • demonstrate competence in knowledge of DMR policies and procedures in: abuse/neglect; incident reporting; human rights; confidentiality; handling fire and other emergencies, prevention of sexual abuse; knowledge of approved and prohibited physical management techniques • demonstrate competence in their role necessary to safely support the individual as described in the IP • Medication Administration * * if required by the individual supported

SERVICE: Supported Employment:

Certification	Individual Qualifications
Self- directed *Ind/Family Agreement with DMR-ISA *Ind/Family or surrogate demonstrates ability to manage own supports *Ind/Fam utilizes an approved FIO **Agency** Enrolled as a Qualified Provider of Supported Employment Services	Prior to Employment • 21 years of age • criminal background check • registry check • demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse. • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP • ability to participate as a member of the circle if requested by the individual • demonstrate understanding of IP

SERVICE: IS Habilitation and Supported Living:

PROVIDER QUALIFICATIONS

IS Habilitation		**Supported Living**	
	Individual Qualifications		Individual Qualifications
Certification *Ind/Family Agreement with DMR-ISA *Ind/Family or surrogate demonstrates ability to manage own supports *Ind/Fam utilizes an approved FIO **Agency** Enrolled as a Qualified Provider of IS Habilitation	Prior to Employment • 18 yrs of age • criminal background check • registry check Prior to being alone with the Individual: • demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques • demonstrate competence/knowledge in areas described in the Individual Plan to support the health and welfare of the individual • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan • ability to participate as a member of the circle if requested by the individual • demonstrate understanding of Person Centered Planning • ability to communicate effectively with ind/family • ability to complete necessary documentation • Medication Admin*	Certification *Enrolled as Qualified Providers of Supported Living with DMR and meet all applicable regulations.	Standards as described in Contract and regulations: Prior to Employment: • 18 yrs of age • criminal background • registry Training w/in 60 days (can not work alone until training completed) • Medication Admin* • Communicable disease/OSHA • FA and CPR • Abuse and Neglect • Sexual Abuse Prevention • Emergency Procedures • Confidentiality • Human Rights • Incident Reporting • Planning and Provision of services • Recognition of Approved and Prohibited Physical Management Techniques • Behavioral techniques based on the individual(s) supported • Additional training as required by the team/circle specific to support the individual's health, welfare and personal outcomes as described in the IP

* if required by the individual supported

SERVICE: Group Day Services

Certification	Individual Qualifications
Agency Only Enrolled with DMR as a Provider of Group Day Services	Standards as described in current Contract : Prior to Employment: • 18 yrs of age • criminal background check • registry check Training w/in 60 days (can not work alone until training completed) • Medication Administration * • Communicable disease/OSHA • FA and CPR • Abuse and Neglect • Sexual Abuse Prevention • Confidentiality • Human Rights • Incident Reporting • Planning and Provision of services • Behavioral techniques based on the individual(s) supported and knowledge of approved and prohibited physical management techniques • Additional training as required by the team/circle specific to support the individual's health, welfare and personal outcomes as described in the IP

SERVICE: Individualized Day Support :

Certification	Individual Qualifications
Self- directed *Ind/Family Agreement with DMR-ISA *Ind/Family or surrogate demonstrates ability to manage own supports *Ind/Fam utilizes an approved FIO **Agency** Enrolled as a Qualified Provider of Individualized Day Support with DMR.	Prior to Employment • 18 yrs of age • criminal background check • registry check • have ability to communicate effectively with the ind/family • have ability to complete record keeping as required by the employer Prior to being alone with the Individual: • demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse; and knowledge of approved and prohibited physical management techniques • demonstrate competence in their role necessary to safely support the individual as described in the IP • demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific outcomes as described in the IP • ability to participate as a member of the circle if the individual requests their participation • demonstrate understanding of Person Centered Planning • Medication Administration*

- if required by the individual supported

SERVICE: Consultative Services:

Certification	Individual Qualifications
Documentation of applicable licensure/certification from the Department of Public Health or qualifications as indicated.	Psychology Licensure per CGS Chapter 383 Speech Therapy Licensure per CGS Chapter 399 Occupational Therapy Licensure per CGS Chapter 376a Physical Therapy Licensure per CGS Chapter 376 Dietitian/Nutrition Licensure per CGS Chapter 384b Counseling Licensure per CGS Chapter 383a or 383c (*Marriage and Family Therapist or Professional Counselor*) behavior management Licensed psychologist or appropriate training: • Masters degree in psychology, special education or applied behavior analysis and • Course work in human behavior and • At least one year experience working with people with mental retardation

D **SERVICE: Family and Individual Consultation and Support (FICS):**

Self-Directed		Agency	
	Individual Qualifications		Individual Qualifications
Certification *Ind/Family Agreement with DMR-ISA *Ind/Family or surrogate demonstrates ability to manage own supports *Ind/Fam utilizes an approved FIO **Agency** Enrolled as a Qualified Provider of FICS	Prior to Employment • 21 yrs of age • criminal background check • registry check • ability to complete necessary documentation • demonstrated ability, experience and/or education to assist the individual and/or family in the specific areas of support as described by the circle in the Individual Plan. • demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques	Certification *Enrolled as Qualified Providers of FICS with DMR	Prior to Employment: • 21 yrs of age • criminal background check • registry check • Five years experience in working with people with mental retardation involving participation in an interdisciplinary team process and the development, review and implementation of elements in an individuals plan of care. • One year of the General Experience must have involved supervision of direct care staff in a residential program OR responsibility for developing, implementing and evaluating individualized programs for people with mental retardation in the areas of behavior, education or rehabilitation. **Substitutions Allowed:** College training in programs related to supporting people with disabilities (social service, education, psychology, rehabilitation etc.) may be substituted for the General Experience on the basis of fifteen (15) semester hours equalling one-half (1/2) year of experience to a maximum of four (4) years. • demonstrate competence in knowledge of DMR policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B, Attachment 1

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION

Procedure No. I.C.2.PR.011 **Issue Date:** January 11, 2002
Subject: Fiscal Intermediary Contracting Process **Effective Date:** Upon issue
Designated Area of Responsibility: Individual Supports

Purpose

To establish the Department of Mental Retardation's process for preparing and executing contracts with providers of Fiscal Intermediary services, including the establishment of contract language, fee schedules and performance objectives; forms to be used; timelines for processing contracts for approval; payment for approved contractual services.

Applicability

These procedures apply to Department of Mental Retardation Fiscal/Business Offices and other DMR staff having responsibility for Fiscal Intermediary Contract preparation and payment.

Definitions

(see section definitions)

Implementation

1. The DMR Operations Center in conjunction with appropriate regional staff will solicit regional and central office input for changes to the current Fiscal Intermediary Services Contract nine months prior to the start of the new contract period. These changes can address contract/language, performance objectives, fee structure, and other parameters.

2. Six (6) months prior to the start of the new contract period, the DMR Operations Center will present a draft of the Contract (Personal Services Agreement) to the Director of Legal and Government Affairs for review. The approved version of the Contract will be finalized within forty-five (45) days.

3. The DMR Operations Center will prepare and distribute a Sample Contract to the regional offices four (4) months prior to the start of the new contract period.

4. Each region will follow the Sample Contract and the Personal Services Agreement Instruction Booklet and prepare a separate contract for each provider of Fiscal Intermediary services in that Region. Each Region may establish its own

regional specific performance objectives, and determine a maximum contract value for each FI based on the number of persons served and the length of the contract.

5. The regions will enter the contracts' financial data into the Contract Management System (CAMRIS Spending Plan) to ensure that funds are available to pay for services authorized by the contracts.

6. Three (3) months prior to the start of the new contract period the regions will send the contracts and signature instructions to the FIs. The Fiscal Intermediaries will have thirty (30) days to review, sign and return the contract to the regions.

7. The regions will forward the signed contracts and contract/lease face sheets to the DMR Operations Center at least forty-five (45) days prior to the start of the new contract period. The Operations Center will review and approve contracts, and forward them to the Office of the Attorney General or the Office of Policy and Management (as determined by the contract value and length of service period). The Operations Center will work with the Office of the Attorney General and/or the Office of Policy and Management to ensure that the contract terms and conditions are acceptable.

8. When the contracts have received final approval they will be returned to the Operations Center, which will forward them to the regions at least fifteen (15) days before the contract period starts. Regions will send copies of the contracts to the Fiscal Intermediaries immediately thereafter.

9. The regions will establish a separate account at the State Comptroller's Office for each Fiscal Intermediary contract. The initial deposit (commitment) of funds will be made at the earliest opportunity; it will represent approximately four (4) months of service payments. When monthly bills for actual services rendered are submitted by the Fiscal Intermediaries, they will be reviewed by the region to verify accuracy (services provided and rates charged). The bills will be processed for payment; a copy of the DMR-generated invoice will be sent to the Fiscal Intermediaries to provide details about the payment they will be receiving.

10. The regions will ensure that adequate funds are available for paying future billings by depositing (committing) additional funds periodically and by managing their financial resources to protect the monies required to pay for contracted Fiscal Intermediary services throughout the contract period.

11. Contract Amendments may be prepared as needed to change parameters such as the contract period, total cost, fee schedule and performance objectives. Amendments will be processed by following steps #5 through #8 above.

12. Regions will meet with FIs at least annually and prior to contract renewal. These meetings will be coordinated by the lead region.

13. The operation center will assign a lead region for each FI. The lead region will act as the primary contact for statewide issues and communications. Annually the lead region will convene a meeting of the FI and all contracting regions for performance evaluation. In the case of poor performance on a statewide basis, the lead region is responsible for all communication and written notification of remedies needed, time frames for compliance.

References

- Connecticut General Statutes 4-8 and 17a-210
- Personal Services Agreement Instruction Booklet

APPENDIX B, ATTACHMENT 2

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION

Procedure No. 1.C.2.PR.012 **Issue Date:** January 11, 2002
Subject: Fiscal Intermediary Contract Management **Effective Date:** Upon release
Designated Area of Responsibility: Individual Supports

A. Purpose

To establish the Department of Mental Retardation's performance and monitoring criteria for contracted services from fiscal intermediary service providers.

B. Applicability

This procedure applies to DMR staff with FI administration and management responsibilities and all agencies that contract with the department to provide fiscal intermediary services to individuals and family members who have Individual Support Agreements (ISAs) with the department.

C. Definitions

(see section definitions)

D. Implementation

General Requirements

1. *Each region will enter into contract with Fiscal Intermediary (FI) agencies for the purpose of providing fiscal support and accountability for those individuals who have Individual Support Agreements. The role of the FI is defined through the contract process*

2. *The DMR Operation Center will establish a lead region for each FI.*

3. *Each region will designate a contact person for all FI related issues, including but not limited to, FI and consumer conflict resolution, fiscal reporting issues, payment for services, FI performance and coordination and communication among all parties. It will be the responsibility of each region to forward all information associated with any FI related issues to both the relevant FI, other regions as appropriate and to the department's Central Office Operations Center.*

Reporting Requirements

1. *As identified in the contract, the FI will submit to each region:*

- *Monthly cash accountings reports for each ISA*
- *Quarterly Reconciliation reports*
- *End of the Year Cost Settlement reports*

2. *These reports will be submitted in the format designated by the department.*

3. FI's will send monthly reports to all individuals with ISAs or their sponsoring family members, and the appropriate regional designees, within 15 days of the end of the month.

4. FI's will send quarterly reports to their respective regions within 15 days of the end of the quarter.

5. Regions will forward quarterly reports to the department's Central Office within 45 days of the end of the quarter.

6. The fourth quarter report will also function as the end of year report.

Invoicing Requirements

1. FI's will submit invoices for their administrative services according to the fee schedule outlined in their contracts with the department.

2. Invoices for administrative services will be submitted to the regional designees within 30 days of the end of the billing month.

3. Regional designee will submit FI invoices to the regional fiscal designees for reconciliation and payment.

4. The final submission of invoices for the end of the fiscal year billing(bills submitted for May services) must be submitted by the 15th of June of that fiscal year.

Adherence To Budget

1. After each ISA has been approved in DMR's Central Office and returned to the region for activation, the regional designee will forward a copy of the Automated Budget to the FI.

2. FIs are authorized to reimburse or pay prospectively for only those goods, services and support, which are delineated as line items in the ISA. Any deviation from this requires either an Amendment or Adjustment, as defined in the Individual Support procedures.

3. Any request to add or change a line item is a regional responsibility and the FI will direct the consumer and/or sponsoring family member back to their Support Broker or regional designee.

Monitoring

1. It is the responsibility of each region to monitor FI compliance with all the provisions of the contract. The regional designee will answer questions and address concerns brought by the FI's and consumers, and will seek to resolve any conflicts among parties.

2. In accordance with the terms of the contract FI's provide:

- Payment for services, goods, and supports as defined in the automated budget.

- Reporting of cash income, expenses and surpluses, on a monthly and quarterly basis.

- Adherence to all state, federal tax and labor laws, regulations, and all necessary payments to those regulatory agencies as appropriate.

- Assistance to consumers to ensure their adherence to federal and state employment requirements.

- Assurance that no payments are made beyond those that are defined in the automated budget without proper approval and documentation.

3. If a region identifies an area of non-compliance with the terms of the contract, the regional designee will contact the FI with the intent of resolving the situation. This contact may take the form of a phone conversation or a formal meeting. If there is a statewide issue, the lead region will assume this responsibility.

4. Within two weeks of contact, the regional designee will send a written summary of the discussion to the FI, the DMR operation center and other regions contracting with the FI. This memo will identify the areas of noncompliance, the corrective actions required and timeframes.

5. If the specified actions are not taken within the timeframes outlined in the memo and the contract noncompliance remains, a second memo will be sent to the FI, and interested parties. This memo will serve to put the FI on notice again of the noncompliance and the actions required. At this time the suspension of client referrals may be imposed, and a warning issued that continued failure to follow contract requirements may result in termination of the contract. These actions will also be delineated in the memo.

6. If following the second memo, the noncompliance remains, all parties including Regional Directors, the Commissioner and Deputy Commissioner and the Director of Legal and Governmental Affairs will be notified that appropriate steps will be taken to terminate the contract in accordance with the required legal procedures.

7. The Regional Designee will notify the DMR Operation Center of contract issues as soon as they arise. The Operation Center may assign someone to be party to the above deliberations between the FI and region(s). The responsible region will ensure that the Operation Center is apprised of all actions and receives copies of all related correspondence and meeting minutes.

Resolution of issues and conflicts internal review of the issue. The regional designee will *between FI and Consumer*

1. When an individual, family member or FI identifies an issue to the broker, the regional designee for the FI will conduct an develop a plan of resolution and discuss the plan with the parties involved. If all parties are in agreement and the plan is implemented, the designee will consider the issue resolved and keep a record of such activities.

E. References

Personal Service Agreement Form CO-802

APPENDIX B-3
KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

___ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

__X__ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C-ELIGIBILITY AND POST-ELIGIBILITY

Appendix C-1--ELIGIBILITY

Medicaid Eligibility Groups Served

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1.____ Low income families with children as described in section 1931 of the Social Security Act.

2.____ SSI recipients (SSI Criteria States and 1634 States).

3.__X__ Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4.__X__ Optional State supplement recipients

5.____ Optional categorically needy aged and disabled who have income at (Check one):

a.____ 100% of the Federal poverty level (FPL)

b.____% Percent of FPL which is lower than 100%.

6.__X__ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

__X__ A. Yes ___B. No

Check one:

a.____ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1)___A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2) X Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___Medically needy without spenddown in 209(b) States. (42 CFR 435.330)

(5)___Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6) X Other (Include statutory reference only to reflect additional groups included under the State plan.)
Would be eligible for FMA as categorically needy if residing in a long term care facility (LTCF)
Would, without such services, require care in an LTCF.

7.____ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8.____ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

_____

_____

_____

_____

APPENDIX C-2--POST-ELIGIBILITY

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under □435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (□435.217). For individuals whose eligibility is not determined under the spousal rules (□1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR □435.726 and □435.735 just as it does for other individuals found eligible under □435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under □1924.

REGULAR POST-ELIGIBILITY RULES--□435.726 and □435.735

- The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

- If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

- If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.

- If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a

family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--□1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of □1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The □1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in □1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the □1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1._____ SSI State**.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. 435.726--States which do not use more restrictive eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.___ The following standard included under the State plan (check one):

(1)___SSI

(2)___Medically needy

(3)___The special income level for the institutionalized

(4)___The following percent of the Federal poverty level):____%

(5)___Other (specify):

_____

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

_____

_____

_____

Note: If the amount protected for waiver recipients in item 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2. and 3. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

_____

_____

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State□s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %____ of ____ standard.

E.___ The amount is determined using the following formula:

_____

F.____ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) X 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. X The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) X The following percentage of the Federal poverty level: 200 %

(5) ___ Other (specify):

_____

_____

B. ___ The following dollar amount:
$ _____ *

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

_____

_____

_____

Note: If the amount protected for waiver recipients in 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under 435.217, enter NA in items 2. and 3. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121: _____

B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of _____

E.___ The following formula is used to determine the amount:

_____

_____

_____

F._X_ Not applicable (N/A)

3. family (check one):

A.___ AFDC need standard

B._X_Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State□s approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be

revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

_____

_____

_____

F.___ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d) X The following percent of the Federal poverty level: 200 %

(e)___ The following dollar amount
$___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

_____

_____

_____

(g)___ Other (specify):

_____

_____

_____

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

_X_ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

_____

_____

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

___ Other (Specify):

_____

_____

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)

___ Registered Nurse, licensed in the State

___ Licensed Social Worker

___ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

___ Other (Specify):

_____

_____

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

___ "Tickler" file

_X_ Edits in computer system

_X_ Component part of case management

___ Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

___ By the Medicaid agency in its central office

___ By the Medicaid agency in district/local offices

___ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

_X_ By the case managers

___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

___ By service providers

___ Other (Specify):

_____

_____

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

_X_ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

Individuals participating in this waiver will not lose their eligibility for the waiver due an increase in the need for covered service that causes the total need for the relevant service(s) to exceed the maximum permitted amounts established by the state unless the state has evaluated the individual and determined that the individual's health and welfare cannot be assured by any one or any combination of the following:

- **Adding more available natural supports; and**
- **Accessing available non-waiver services, other than natural supports; and**
- **Accessing funds held in Regional CT DMR Regional risk funds on a non-annualized basis.**

To the extent that the above efforts are unsuccessful, and the state finds that the absence of sufficient service(s) prevents the state from being able to assure the individual's health and welfare, the following shall apply:

- **Individuals will be given the opportunity to apply for an alternative CT MR HCBS waiver for which the individual is eligible that may more adequately respond to the service needs of the individual, to the extent that such waiver openings exist. Individuals in emergency situations are permitted to access services on a priority basis before other individuals on the waiting list per DMR Procedure I. B. PR. 002.**
- **Individuals will be afforded an opportunity for placement in an ICF/MR including a state operated Regional Center.**

- **Individuals will be informed and given the opportunity to request a fair hearing if the state proposes to terminate the individual's waiver eligibility consistent with the requirements under 42 CFR 431.210, .211, .221 and .430 subpart D. Waiver services will be continued during the pendency of a timely requested hearing including the provision of any emergency services available within the DMR Regional Risk Pool, even if the services exceed the total benefit package limitation in this waiver.**

- **Participants in any other CT MR HCBS waiver(s) shall be afforded the opportunity to apply for enrollment on this waiver if their health and welfare can be assured within the benefit package limitations of this waiver.**

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

At the time an individual requests HCBS waiver services under this waiver, the Regional DMR office in which the person resides will explain the services available under the IFS waiver. The individual will be informed of the amount, scope and duration of services and benefit package limitations available in this IFS waiver.

   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Client file maintained by the case manager

APPENDIX D-4
ATTACHMENT 1

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL RETARDATION

HOME AND COMMUNITY BASED SERVICES
SERVICE SELECTION FORM

Recipient	Region	DMR #	Date
_____	_____	_____	_____

The purpose of this form is to document that when a recipient is determined to be likely to require the level of care provided in an ICF/MR, the recipient or his or her legal representative will be informed of any feasible alternatives under the Home and Community Based Services Waiver and given a choice of either institutional or home and community based services

I have informed the recipient and/or legal representative of the feasible alternatives under the HCBS waiver.

_____ _____
Regional Representative Date

I believe the recipient to be:

- ☐ legally competent (complete "A" below).
- ☐ not legally competent and has legal representative (complete "B" below).
- ☐ legally competent, but may not be able to make informed decisions (complete "C" below).

_____ _____
Regional Representative Date

A. I, the recipient, have been informed of the feasible alternatives for available services. I understand that I may change my selection at any time. At this time I would like to select the following:

☐ Home and Community Based Services ☐ Institutional (ICF/MR) Services

_____ _____
Recipient Date

B. I, the legal representative of the above named recipient, have been informed of the feasible alternatives for available services. I understand that I may change my selection at any time. At this time I would like to select the following:

☐ Home and Community Based Services ☐ Institutional (ICF/MR) Services

_____ _____
Legal Representative Date

C. The interdisciplinary team, which includes the recipient, believe that he or she, although legally competent, may not be able to make a fully informed decision regarding the selection of service delivery. The IDT, with the understanding that it may change the selection at any time, has recommended to the director that it is in the recipient's best interest to make the following selection:

☐ Home and Community Based Services ☐ Institutional (ICF/MR) Services

_____ _____
IDT Chairperson Date

☐ Approved ☐ Disapproved

_____ _____
Director Date

DMR Form 222
Rev. 6/5/97

State of Connecticut
Department of Mental Retardation
Waiver Policy and Program Development Unit

Notice of Denial of Home and Community Based Services Waiver Services

IN RE: APPLICATION OF
DOB:

Materials necessary for determining eligibility for HCBS Waiver services have been received and reviewed by the Waiver Policy and Program Development Unit of the Department of Mental Retardation.

Please be advised that it is the determination of the DMR Waiver Unit that _____ is not eligible for enrollment the HCBS Waiver at this time. The reason for this is you_____. Such a determination is a prerequisite for enrollment or additional waiver services.

If the applicant, and those acting their behalf, are aggrieved by this denial of HCBS waiver services, a hearing before the Department of Social Services (DSS), the single state agency for Medicaid administration, may be requested using the enclosed Hearing Request form.

DATE OF DECISION:

Issued to:

Cc: _____, Regional Director
_____, Case Manager

State of Connecticut
Department of Social Services

Request for Administrative Hearing
Home and Community Based Services (HCBS) Waiver
For Persons with Mental Retardation

NOTICE: This form is for use in requesting an Administrative Hearing to contest, or challenge, certain decisions made by the Connecticut Department of Mental Retardation in carrying out various operational functions and responsibilities for the HCBS Waiver. The decisions of DMR for which an Administrative Hearing may be requested are: (1) A decision finding that an individual is **not eligible** for HCBS waiver services (and denial of HCBS waiver enrollment); (2) A decision finding that a person enrolled in the HCBS waiver (a "recipient") does not currently need one or more additional services he or she has requested under the HCBS waiver; or (3) A decision regarding the funds allocated to meet an approved "need" for one or more HCBS waiver Services. **ANY** request for Administrative Hearing must be accompanied by a copy of the contested, or challenged, decision which is issued by the DMR Waiver Unit. A request for administrative hearing must be made, in writing, to the Department of Social Services (DSS), which administers the HCBS waiver as the "single state Medicaid agency, at the address below within **sixty (60) days** of receipt of the Notice of Decision from the DMR Waiver Unit.

Submit by Mail and/or Facsimile

TO: **The Office of Legal Counsel, Relations and Administrative Hearings**
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
FAX No. (860) 424-5729

Date: _____

I, _____ request an Administrative Hearing before
(*applicant/recipient/legal representative*)

the Department of Social Services (DSS) to contest a Home and Community Based Services (HCBS) waiver decision made by the Department of Mental Retardation (DMR) concerning _____. A copy of the DMR "Notice of Decision" for the
(applicant/recipient)

matter(s) for which I request an administrative hearing is enclosed herewith.

I am requesting an administrative hearing to contest (*Check either 1, OR 2, and/or 3.)*

1. ____ The DMR decision denying eligibility for services under the HCBS waiver.

2. ____ The DMR decision denying provision of certain "needed" waiver services for which proper application has been made _____

_____

_____

_____

(*identify relevant waiver services*).

3. ____ The DMR decision determining the level/amount of funds which has been allocated to meet my needs for the following waiver service(s), _____

_____

_____

_____

(*Identify waiver services for which you claim funding is in adequate*).

The DSS Office of Legal Counsel, Regulations and Administrative Hearings will make reasonable efforts to conveniently schedule the hearing on this matter. In making this request I understand the necessity of my attendance at any scheduled hearing in order for the matter to proceed.

Please advise the DSS Office of Legal Counsel, as soon as possible prior to the convening of the requested hearing, if some or all of the matter(s) for which a hearing is requested are resolved.

_____	_____
Applicant/recipient(Print)	*Guardian/representative(Print)*
_____	_____
_____	_____
_____	_____
(Address and Telephone. Number)	*(Address and Telephone. Number)*
_____	_____
HCBS Applicant/Recipient	***Date***
_____	_____
Guardian/Conservator/Legal Representative	*Date*

Copy By Mail and/or Facsimile To: **HCBS Waiver Unit**
Department of Mental Retardation
460 Capitol Avenue
Hartford, CT 06106
FAX No. (860) 418 - 6001

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

___ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

_X_ Case Manager

___ Other (specify):

_____

_____

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid agency central office

___ At the Medicaid agency county/regional offices

_X_ By case managers

___ By the agency specified in Appendix A

___ By consumers

___ Other (specify):

_____

_____

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

___ Every 3 months

___ Every 6 months

_X_ Every 12 months

___ Other (specify):

_____

_____

_

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:
A professional staff person at the Department of Social Services reviews a sample of plans of care on a quarterly basis. These plans are reviewed to assure that the following requirements are met:

1. **Services provided are identified.**
2. **Relevant needs are identified.**
3. **Frequency, duration and limitations of services are identified.**
4. **Providers of waiver services are identified.**
5. **Evidence of a team process.**
6. **Evidence of client participation.**
7. **Plan of services based on assessment**
8. **Evidence of provider reviews.**

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

Each Individual Plan of Care is developed utilizing Person-Centered Planning principles as described in the attached CT DMR Individual Planning Guide. The Individual Plan will address how potential emergency needs of the individual will be met.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

__X__ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

____ Other (Describe in detail):

_____

_____

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

      _X_ Yes

      ____ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   _X_ All claims are processed through an approved MMIS.

   ____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

__X__ The Medicaid agency will make payments directly to providers of waiver services.

____ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

_____

_____

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

_____

_____

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$6,768	$5,822	$163,861	$3,576
2	$19,970	$5,938	$167,138	$3,647
3	$20,261	$6,057	$170,481	$3720
4				
5				

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	3115
2	3390
3	3693

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

__X__ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1 X 2 3 4 5

Waiver Services	#Undup. Recip (Users)	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Support	480	265	15.00	$1,908,000
Respite	270	6	220.00	$356,400
IS Habilitation	450	240	25.00	$2,700,000
Supported Living	997	102	62.00	$6,305,028
Supp Emp	417	70	73.00	$2,130,870
Group Day Services	999	70	73.00	$5,104,890
Individualized Day Supports	275	70	73.00	$1,405,250
Env Adaptations	18	1	4,800.00	$86,400
Vehicle Mods	10	1	2,400.00	$24,000
Transportation	490	6	200.00	$588,000
Adaptive Aids	70	1	750.00	$52,500
Personal Emergency Response	100	6	30.00	$18,000
Fam Tng	180	6	58.00	$62,640
Consultative Services	190	6	166.00	$189,240
Family/Individual Consultation & Suppor	100	6	250.00	$150,000
GRAND TOTAL (sum of Column E)				$21,081,218
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				3,115
factor d (Divide total by number of recipients:				$6,768
AVERAGE LENGTH OF STAY:		102		

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1___ 2_X_ 3___ 4___ 5

Waiver Services	#Undup. Recip (Users)	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Support	525	530	15.00	$4,173,750
Respite	290	12	222.00	$772,560
IS Habilitation	495	480	25.00	$5,940,000
Supported Living	1085	350	63.00	$23,924,250
Supp Emp	434	235	74.00	$7,547,260
Group Day Services	1039	235	74.00	$18,068,210
Individualized Day Supports	286	235	74.00	$4,973,540
Env Adaptations	18	1	4,850.00	$87,300
Vehicle Mods	10	1	2,500.00	$25,000
Transportation	500	12	200.00	$1,200,000
Adaptive Aids	90	1	750.00	$67,500
Personal Emergency Response	120	12	30.00	$43,200
Fam Tng	180	12	59.00	$127,440
Consultative Services	210	12	166.00	$418,320
Family/Individual Consultation & Suppor	110	12	250.00	$330,000
GRAND TOTAL (sum of Column E)				$67,698,330
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				3,390
factor d (Divide total by number of recipients:				$19,970
AVERAGE LENGTH OF STAY:		349		

APPENDIX G-2
FACTOR D
LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1___ 2___ 3_X_ 4___ 5___

Waiver Services	#Undup. Recip (Users)	Avg. # Annual Units/Users	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
Personal Support	575	530	15.00	$4,571,250
Respite	320	12	225.00	$864,000
IS Habilitation	545	480	25.00	$6,540,000
Supported Living	1182	350	64.00	$26,476,800
Supp Emp	473	235	75.00	$8,336,625
Group Day Services	1132	235	75.00	$19,951,500
Individualized Day Supports	312	235	75.00	$5,499,000
Env Adaptations	25	1	5,500.00	$137,500
Vehicle Mods	20	1	2,600.00	$52,000
Transportation	550	12	200.00	$1,320,000
Adaptive Aids	100	1	750.00	$75,000
Personal Emergency Response	135	12	33.00	$53,460
Fam Tng	180	12	60.00	$129,600
Consultative Services	230	12	166.00	$458,160
Family/Individual Consultation & Suppor	120	12	250.00	$360,000
GRAND TOTAL (sum of Column E)				$74,824,895
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				3,693
factor d (Divide total by number of recipients:				$20,261
AVERAGE LENGTH OF STAY:		349		

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Refer to attachment G for the methodology used to ensure that room and board is not included in Medicaid rates.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Respite

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Attachment G

ROOM & BOARD

The state has several mechanisms to ensure that room and board costs are not included in the request for federal reimbursement for residential supports in the HCBS Waiver.

1. Cost standards have been established for individual support agreements that specifically exclude room and board as allowed costs. These agreements are used to fund services which are self directed and provided in the recipient's home.
2. Each region has a program resource allocation team which reviews applications for the HCBS waiver. These teams ensure that appropriate resources are provided and that CMS requirements are met.
3. A costing methodology has been established which specifically excludes room and board expenses from the established rates used to request federal reimbursement.
4. The DMR Central Office Waiver Unit reviews waiver applications before they are processed.
5. Room and board is an audit item for DMR auditors when they review regional programs.

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

__X__ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.
>
> Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

____ Based on CMS Form 2082 (relevant pages attached).

__X__ Based on CMS Form 372 for years __1__ of waiver # 0153.90.R2, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

__X__ Other (specify):

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on institutional cost trends shown by CMS Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

__X__ Based on trends shown by CMS Form 372 for years __1__ of waiver # 0153.90.R2, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

____ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

____ Other (specify):

_____

_____

_____

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

Factor G' is computed as follows (check one):

____ Based on CMS Form 2082 (relevant pages attached).

__X__ Based on CMS Form 372 for years __1__ of waiver # 0153.90.R2, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

_____

_____

_____

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D:	$6,768		FACTOR G:	$163,861
FACTOR D':	$ 5,822		FACTOR G':	$ 3,576
TOTAL:	$12,590	<	TOTAL:	$167,437

YEAR 2

FACTOR D:	$19,970		FACTOR G:	$167,138
FACTOR D':	$ 5,938		FACTOR G':	$ 3,647
TOTAL:	$25,908	<	TOTAL:	$170,785

YEAR 3

FACTOR D:	$20,261		FACTOR G:	$170,481
FACTOR D':	$ 6,057		FACTOR G':	$ 3,720
TOTAL:	$26,318	<	TOTAL:	$174,201